TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy

Respondent Name
Accident Fund Insurance Company of America

MFDR Tracking Number
M4-16-2701-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
May 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the insurance carrier took no action within the 45-day period as required by the applicable regulations, the Pharmacy now seeks payment of the claim in full."

Amount in Dispute: $1144.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denies payment for the compounded pain cream because it was not prescribed by the claimant's treating doctor and was not medically necessary. Carrier further asserts that preauthorization for the compound drug was required but not sought by the Requestor. Finally, Carrier contends that the cost of the prescription compound was excessive and unreasonable."

Response Submitted by: Stone, Loughlin & Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2015	Prescription Medication (Compound Cream)	$1144.86	$1144.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of medical bills.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
5. 28 Texas Administrative Code §134.503 sets out the fee schedule for pharmaceutical services.

6. No explanations of benefits were submitted related to the services in dispute.

Issues

1. Were the services in question denied in accordance with 28 Texas Administrative Code §133.240?
2. Did the insurance carrier appropriately raise denial issues in their position statement?
3. What is the total reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The requestor states in their position statement that they have not received a response to billing for the services in question. The submitted documentation supports that the requestor submitted a medical bill in accordance with 28 Texas Administrative Codes §§133.10 and 133.20.

   28 Texas Administrative Code §133.240(a) states,

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   Review of the submitted documentation does not support that the insurance carrier took final action on the submitted medical bill in accordance with 28 Texas Administrative Code §133.240.

2. In their position statement, the insurance carrier argued that were denying the services in question "because it was not prescribed by the claimant's treating doctor," because it was not medically necessary, because it required preauthorization, and because "cost of the prescription compound was excessive and unreasonable." 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

   Because the denial reasons stated in their position statement were not presented to the requestor prior to the date the request for MFDR was filed, they will not be considered for this dispute.

3. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503(c), which states:

   > The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   > (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   > (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
   > (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   > (A) health care provider…

   The requestor is seeking reimbursement for a compound of the generic drugs Ketoprofen, NDC 38779007805; Amitriptyline, NDC 38779018908; Baclofen, NDC 38779038808; Amantadine, NDC 38779041109; Gabapentin, NDC 38779246108; and Versatile Base Cream, NDC 51552134308. The disputed medication was dispensed on November 3, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
11/3/15	Ketoprofen	(10.45 x 12.0 x 1.25) + 4.00 = $160.75	$125.37	$125.37	$0.00	$125.37
11/3/15	Amitriptyline	(18.24 x 2.4 x 1.25) + 4.00 = $58.72	$43.73	$43.73	$0.00	$43.73
11/3/15	Baclofen	(35.63 x 4.8 x 1.25) + 4.00 = $217.78	$171.04	$171.04	$0.00	$171.04
11/3/15	Amantadine	(24.225 x 9.6 x 1.25) + 4.00 = $294.70	$232.52	$232.52	$0.00	$232.52
11/3/15	Gabapentin	(59.85 x 6.0 x 1.25) + 4.00 = $452.88	$359.14	$359.14	$0.00	$359.14
11/3/15	Versatile Base Cream	(2.50 x 85.2 x 1.25) + 4.00 = $270.25	$213.06	$213.06	$0.00	$213.06

4. The total allowed amount for the disputed service is $1144.86. The insurance carrier paid $0.00. A reimbursement of $1144.86 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1144.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1144.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 6, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.